

### Maternity Care Program Smoking Cessation

1. \_\_\_\_\_ was smoking \_\_\_\_\_ cigarettes per day at her first visit.
2. \_\_\_\_\_ was not smoking at her first visit.
3. Smoking Cessation information given on \_\_\_\_\_.
4. Provided **Smoking Quitline number 1-800-Quit-Now (1-800-784-8669)** on \_\_\_\_\_.
5. Counseled on Smoking and Effects on Pregnancy on \_\_\_\_\_.
6. \_\_\_\_\_ was not smoking as per interview at postpartum visit.

#### 1<sup>st</sup> Encounter

Date	Smoking Status	Action Taken	Initials
	<input type="checkbox"/> Smoking <input type="checkbox"/> Has Quit <input type="checkbox"/> Using Patches	Counseled and <input type="checkbox"/> Provided support <input type="checkbox"/> Praised and provided support	

#### 2nd Encounter

Date	Smoking Status	Action Taken	Initials
	<input type="checkbox"/> Smoking <input type="checkbox"/> Has Quit <input type="checkbox"/> Using Patches	Counseled and <input type="checkbox"/> Provided support <input type="checkbox"/> Praised and provided support	

#### Other Encounter

Date	Smoking Status	Action Taken	Initials
	<input type="checkbox"/> Smoking <input type="checkbox"/> Has Quit <input type="checkbox"/> Using Patches	<input type="checkbox"/> Counseled <input type="checkbox"/> Praised	